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JOURNAL OF CLINICAL PASTORAL WORK

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STATEMENT OF AIMS

TO BRING together descriptive accounts of pastoral work with individuals and groups, in parish, hospital and prison, and to encourage parish clergy and chaplains to share their understanding and methods.

TO DEMONSTRATE the use of concise note-taking in clarifying the pastoral process and in providing a factual basis for pastoral work.

TO CLARIFY from specific pastoral situations both the religious needs of the parishioner and the principles of relating to other professions also concerned with a ministry to people; especially medicine, penology, social work, nursing and education.

TO USE the insights of other professions, not in imitation of these professions, but as a means of further strengthening the clergyman's understanding of the needs and resources of his people and of his role and relationship to them.

TO THROW light on the elements of normal Christian living through clinical accounts of the pastoral care of the adequate and wholesome person.

TO CONSIDER the principles and methods of Clinical Pastoral Training of the theological student, the nature of the supervision involved, and its relation to other elements in the curriculum; recognizing the growing interest in this educational approach in helping the student make real his understanding and practice his work in the seminary.

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A CHAPLAIN LOOKS AT PSYCHIATRY*

ROBERT A. PRESTON, CHAPLAIN
WINTER V.A. HOSPITAL
TOPEKA, KANSAS

Early in his time of affliction Job cried out:
"What is my strength, that I should hope,
And what is mine end, that I should prolong my life?"

This double question is echoed countless times today by troubled people. One might say, in an age of specialization, that the first line belongs to the realm of the psychiatrist: what is the individual's strength; what are his personality assets for enduring the stresses of life? The second line asks about the meaning and destiny of life and therefore is referred to the clergy. Distressed people, however, are not likely to pause in the depths of their misery for the purpose of working out this neat distinction. They want help "all over." Their needs oblige psychiatrists and religionists to come to understand each other and work together.

Most of the writings which have endeavored to bring harmony between the forces of religion and psychiatry have emphasized three mutual concerns: the alleviation of present suffering, the turning of past liabilities into assets, and the prevention of avoidable problems in the future. It is not hard to outline the goals of cooperation. Religious leaders and psychiatrists agree on the desirability of helping people. Also, representatives of each field are eager to have the cooperation of the other. Nevertheless, strong disagreements have existed for a long time. These have centered about academic issues, such as the nature of man, or jurisdictional disputes, *e. g.* whether people need therapy or salvation. Some of these conifIcts have stimulated progress in the clearer definition of concepts; many have been pointless and have done damage to patients and parishioners. How can the differences of outlook between psychiatrists and religious exponents be reconciled without destructive concomitants? How may the areas of common interest be enlarged? These questions may be considered as they

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appear in two kinds of situations: first in the community at large, and second in the clinical setting.

The kind of problem which arises in the community is illustrated by an experience which I had several years ago while seeking support for a new mental hygiene program. I approached a fellow minister whose congregation included some key people in the city. As soon as psychiatry was mentioned he said, "I don't trust psychiatrists. They are amoral. I once had a fine couple in my church. The husband thought there was something the matter with him and went to a psychiatrist. Soon the wife began consulting the same man. Before I realized what was going on they were getting a divorce. In spite of all I could do they went through with it. Both of them dropped out of the church. I am not willing to lend my support to your program . . ." I found that he knew little about the personal complaints of the couple and nothing significant about the psychiatrist. His generalization about all psychiatrists was an exact parallel to many other generalizations which are made in situations of deep prejudice.

A few months earlier I had heard a psychiatrist theorize somewhat like this: "In my practice I have seen fewer psychotic ministers proportionately, than members of other professions. Why? Probably because the ministry is a psychosis in itself. Any man who claims to be the mouthpiece of God can be readily diagnosed. But when a church agrees with his delusion, he is sitting pretty." (Note: the minister mentioned above was never converted to a better point of view; the psychiatrist was.)

These two examples are extremes. I believe that they did not represent a norm of psychiatric or clerical attitudes at the time, and that they are even farther from the norm today, but they show what can develop in the community. Religion centers in the church; psychiatry is at work in private practice or in confidential agencies. Between these foci is a wide gulf where misconceptions may grow. Busy people in each field often neglect to bridge the gulf—they find many reasons not to seek out a member of the other profession to get to know him and what he is trying to accomplish. Three devices can improve matters here: literature, conferences, and the personal efforts of individuals. These are most effective if directed toward genuine acquaintance and collaboration in local projects of mutual significance.

Where sincere efforts have been made toward better relations between psychiatry and religion in the community, the results have been gratifying. Many such efforts have developed out of

clinical observations in which religious values and psychiatric considerations were found to be inseparably blended. Let us turn, then, to the clinical setting, the second type of situation in which psychiatry and religion meet.

In hospitals which have full-time chaplain service, the relationship between religious representatives and members of the psychiatric professions is obviously much more intimate than in the community. As staff associates they penetrate professional façades and get to know each other as people. They deal with the same living data in their work, for here parish and practice coincide. They compare the relative perspectives of health and goodness, not only for the specific patient but also for the social groups involved in his future. They share in the mutual successes and frustrations of treatment programs.

A hospital chaplain learns that generalizations about psychiatrists are unreliable. He becomes aroused when he hears someone say that psychiatrists are anti-religious because he knows many who are deeply religious. He also knows many who criticize a certain approach of religion on the basis of ineptitude; these, for example, point out a patient whose religious training was accompanied by severity too great for his sensitive nature to bear, with a resulting incapacity which defeats the more basic purposes of religion. It is easy for a criticism of this kind to be misconstrued by an aggressive religionist, or by a sensation-peddling journalist.

Once in a while a chaplain meets a psychiatrist who expresses opposition to organized religion in general. My own discussions with members of this small minority indicate that there are two principal sources for such an attitude. The psychiatrist has had painful experiences in his own religious history, and he has observed that members of religious groups fall short of the humanitarian goals of their own faith. An undefensive, objective religious appraisal of this situation reveals that even this psychiatrist is not an enemy of religion. In the first place, he is trying to combat the poor methods which were used on him. In the second place, he is employing a very high standard of human welfare values when he criticizes the inconsistency of religious adherents. Religious leaders criticize the same inconsistency, calling it lukewarmness, indifference, or hypocrisy. The standards by which the psychiatrist is making his judgment in this instance are standards which have a religious ancestry. One of the central aims of religion is to develop in people the ability to make value judgments of a

high type. One who has gained this ability and is using it in the service of people may be likened to Abou ben Adhem. In spite of opinions about organized religion, it is usually possible for a psychiatrist who feels this way and a chaplain to form a good working relationship and a personal friendship.

Personal acquaintance removes many barriers between the psychiatrist and the minister, but something else is necessary to add broader mutual understanding: namely, the experience of looking at the same set of facts. Only in the clinical setting can this be fully realized. As the chaplain learns more about patients he discovers the real basis for a lot of psychiatric opinions about religion. He finds that many patients have tried religious solutions during the onset of their illness but were unsuccessful. Conventional religious resources did not suffice in these instances. Only skilled diagnosis and treatment could answer the needs at the time. Under treatment, many patients relinquish superficial or immature religious attitudes and are enabled to develop more genuine and practicable expressions of religion. Moreover, the chaplain may gain a new appreciation of the depth and significance of certain beliefs and practices as he learns more about the dynamics of personality. Sometimes he may see a psychiatrist show greater respect for the tenacity of a religious attitude than would be shown by the average religious leader of an opposing theological position.

Still further understanding is developed between the psychiatrist and the minister as each learns more about techniques of the other. A small slice of psychotherapy taken out of context can be made to look ridiculous. The same is true of isolated religious precepts. When working along with a psychiatrist, a chaplain will see the total perspective and goal of therapy.

On the basis, then, of personal acquaintance, working with the same people, and observing each other's methods and goals, I believe that representatives of psychiatry and religion can come to a real, cooperative, mutual understanding only through shared clinical experience. To make this possible, psychiatrists can give opportunity in hospitals for the expansion of the clinical pastoral training movement. The churches likewise can do more to offer the clinical facilities of their own hospitals to students of psychiatry and to students of religion than they have done in the past. Theological education needs further awakening to the possibilities afforded by clinical experience. All of these developments seem to be moving, but slowly, in a promising direction.

In looking at psychiatry, a chaplain can scarcely avoid analyzing the philosophical assumptions of psychiatrists, trying to discern what they implicitly believe as revealed by their daily work. Dr. Karl Menninger asked me some time ago to jot down a few observations along this line. Accordingly, I wrote the following, expressing what I think psychiatrists believe, whether they put it in words or not:

"You psychiatrists believe that some people can be understood, and by understanding be helped. Behind this belief there is a belief that many people need help. The facts justify these beliefs. Furthermore, you believe that in re-examining your efforts constantly in the light of the results obtained you can discover and affirm a principle of workability. You have concluded that long term results are more important than immediate results. This brings you into the field of social relationships which I shall mention further in a moment.

"You have a belief in the importance and the dignity of the individual human being. It is an assumption, of course, which you make with a dedicated faith, that every individual is worth helping. You believe that each individual has capacities for being destructive, and capacities for being constructive and creative. You feel that it is possible for other human beings like yourselves, granted an understanding of the particular problems or mechanisms of this individual, to guide him in the direction of constructiveness and away from destructiveness. You have demonstrated that it is possible to strengthen the beneficial positive factors in a severe conflict and to restore people to an inner equilibrium. This requires a disciplined honesty in seeking the real sources of trouble, and implies that health demands truthfulness within the self.

"Concerning society you believe that human beings are interdependent, more deeply and crucially than most people realize. The measure of an individual's health is linked in your concept with his level of usefulness in carrying his own responsibilities and contributing to the welfare of others. Hence, you contend, tendencies which are harmful to others are a mark of disorder within the person and arouse your feeling of responsibility for the use of techniques of modification.

"You are more keenly aware than most people of the influence of groups upon the individual because you see in the mental hospital the persons who have been broken by, or at least not helped by, social institutions—domestic, economic, educational, and religious. You sometimes observe that the teaching of religion

has affected individuals in ways which were not intended by the teacher or by the religious leader. Surrounded by the extremes of tragedy, dwelling with the victims of disillusionment and self-destructiveness, you are constantly impressed with the deceptiveness of superficial words and superficial explanations. It leads you to a feeling that there may be praise with the lips while the heart is far away, and hence, that if 'faith is the substance of things hoped for, the evidence of things not seen,' it must be as substantial as possible."

PIONEERING IN LONDON

INNES H. PEARSE, M.D.

THE PECKHAM EXPERIMENT

To be able to come across the Atlantic to represent to the foremost group of social workers of your country the new approach to social work which the Peckham Experiment implies, is a stimulating adventure. I hasten to thank you for the generous and warm hearted hospitality that makes such an occasion as this possible.

The Peckham Experiment, with its laboratory, the Pioneer Health Centre in London, is an experiment in the field of human biology. It is an attempt to study the power or "urge" behind human living, as any physical scientist might set out to study any form of energy in the physical world. The experiment presumes the existence of such an energy or "urge": it also presumes that its evolution will be found to follow certain natural laws: and that those laws will be ascertainable. It presumes last, that where human beings can align themselves with natural law we should see an ordered pattern arise in society as well as a great enhancement in living itself within that society.

Experimental Difficulties

From the outset we are faced with immense experimental difficulties, for, while in the physical world the physical scientists are dealing with uniformities of equal or equivalent quantity, in the living world we are dealing with total diversity—no two identical finger prints the world over; no two similar individuals in any society we might choose for observation. From the outset in this experiment we leave the measurable realm of quantity and enter the, as yet, unmeasurable, field of quality. It is probably difficult to appreciate the significance of this without an understanding of the spontaneous nature of health.

A good deal is known of how order is sustained in the plant and animal world and something of the ecological balance between organism and environment in both fields. Hitherto, the experimental scientist has not turned his attention to the nature and circumstances of order in the great and unexplored field of human

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biology—that is to say in human society. Whenever a sustained pattern has arisen it has been of spontaneous occurrence and has resulted from instinctive action, rather than from a knowledge of natural law.

On the other hand, we have a vast knowledge of dis-order, physical, psychological, social, in man and his society. Strange to say it is commonly assumed that this knowledge of dis-order, by some inverse equation, gives us an equal and valid knowledge of the nature of the order. Who is the expert on health?—the doctor; who is the specialist in psychology?—the psychopathologist; who our chosen advisor in social planning?—the economist and the social worker. Yet in our country the social worker is there by reason of the social ills that have to be assuaged—sickness, poverty, delinquency, break up of marriage, etc.: all of which demand an immediacy of action which is first therapeutic and then preventative rather than cultural in its operation. **By "culture" I mean "growing"**; not the variety of culture often spelt "Kultur"—or even "culture" as understood by the educationalist.

The medical profession which assumes the major responsibility for health is in like case. Its informative science is that of Pathology—the science of disease and disorder. Pathology has progressed through the study of susceptibility to disease. In the phenomenal strides that have been made in this subject we have, as yet, failed to ask the all important question—not how does disease spread?—but, how is it that some persons escape it? For example in every epidemic there are those who, while exposed, do not "take" the infection or do not succumb to the disorder. What then is the nature if their insusceptibility? We know much of the circumstances that cause the re-action of disease. We have yet to study the conditions that engender an actional relationship of ordered ease between organism and environment. We know much of sickness and its processes—we know nothing of the processes of health. What is health: and how is it sustained? It was to find an answer to this question that the Peckham Experiment was devised:—

Experimental Procedure

The first requisite for such an experiment was to select a (sic) healthy specimen of society and to secure circumstances in which such folk would come voluntarily within the field of experiment. Peckham was chosen as an area within our metropolis in which we were likely to find the most healthy specimen of

society—neither too rich, nor too poor, intelligent enough to hold down a good job, independent and competent enough to paddle their own canoes without help or direction from outside. Its people were no social problem group or underprivileged people but a fair section through a wide range of class, wage and culture. Voluntary association in continuity between this group and those conducting the experiment was achieved by forming a health club available daily for the leisure of its members.

The second step was to gain some idea of the sort of machine and engine that each individual who joined the club had to live and to play with. This determined one of the very few conditions of membership of the club—a periodic health overhaul for all who joined. What we, as biologists, attempted to do was to make a **health** overhaul: i.e. a search for what is **right.** This is to be distinguished from a medical overhaul which is a search for what is wrong with the individual.

Early Results

The result up to date of this procedure has been to give us information as to the degree of diagnosable disorder in those who believe themselves .in "health." That is a very interesting disclosure,* but not one that is necessarily pertinent to our own studies. Much more pertinent to us is the fact that in the small number, roughly 10%, of those found to be without diagnosable disorder we do not necessarily find the vitality and capacity for action—for living—that one would anticipate in health. These were often people only half alive; people unaware of the significance of their surroundings, too diffident to explore them—undeveloped people.

Our experiment has told us that the absence of disorder is no measure of health. Health is not in fact any static entity; it is processional—in organism and in environment. Health lies in an actional relationship of organism and environment both evolving in mutual synthesis. In health organism and environment are inseparable; they are mutually related, one living by the other. So the meaning of Health is something nearer to the old intuitive meaning of the word—"wholeness." Its synonym is **holiness; i.e. relatedness within a greater Whole.**

That being so we must cease to use the words health and

*"Biologists in Search of Material"—Faber & Faber, London, 1938. "The Peckham Experiment," Pearse & Crocker—Allen & Unwin, London, 1943. Yale University Press, 1946.

sickness—whether its cure or its prevention—as interchangeable terms, as in the current usage. In Britain we assemble in one building, clinics for the early detection and treatment of tuberculosis, venereal disease, extraction of tonsils, for deinfestation, for infant welfare and ante-natal care, add to it a mortuary for the housing of the dead pending burial, and call the institution a health Centre! We do not even blush for the writer when we read in the morning paper that a new Chair of Child Health is to be inaugurated, the object of which is "to deal comprehensively **with all the diseases** of childhood." I believe the same confusion of language pertains also in your country for I saw recently that the health activities of one of your community centres were billed as lectures on tuberculosis and venereal disease!

It is a strange and new field into which that branch of human biology—the study of natural "order" and ease in man—or **Ethology**—is leading. The new field of investigation has demanded new material and new instruments. Instead of operation theatres, dispensaries, and glass cages to isolate the new born infant from its new found environment—the new type of instruments required are opportunities for action; such things as—swimming pool, theatre, playgrounds, musical instruments, dance floor, cafeteria—all environmental media conductive to personal and social action in a fluid and free environment. To the nature of the free environment I shall return later.

The Pioneer Health Centre, pioneer because it set out on this quest, is in fact a "laboratory" equipped with just such instruments for the continuous use, in their leisure, of those living in its vicinity. The features of its building are large open floor spaces, interrupted only by supporting pillars, so that there are no enclosed rooms or cul-de-sacs limiting free circulation. As well as free circulation everywhere—except in the examination department—there is also everywhere free visibility. This is secured by glass partitions wherever an enclosed space is essential, such as the chamber of the swimming pool, the gymnasium, the theatre. The nature of the building, constituting an open forum in which there is free circulation and free visibility for all at all times is an essential condition of the experiment, for we set out to find out what people would do when they could do what they liked, when they liked, where they liked, and with whom they liked.

The Family

Now as to the nature of the material under observation in this laboratory. With what biological "unit" were we to work?

We had set ourselves the task of investigating the natural order of growth and development in a specimen of human society. In the great process of evolution we had discerned two phases held in equilibrium. One is that of "senescence," demonstrated by the individual who can only grow older and older; the other that of "juvenescence" by which novelty and diversity are introduced into living. This process of juvenescence is manifested only by the mated pair. Neither male nor female alone could thus demonstrate to us the full scope of human growth and development. It is through having children that the individual comes to full maturity—**that the male becomes a man, the female a woman.** And it is through the child that the new is born into society and society is diversified. It is not then with any "unit," as in physical science, but with functional "unity" that we had to deal in setting up our experiment. That has caused us to define, as "family," this unity of the mated pair which hold the biological potentiality of children within an intimate biologically specific environment—the home. So a mother and father with several children, or a young married couple without them are equally "families" in our sense. In either stage of growth they represent a unity with the potentialities for juvenescence or the anewal of society, as well as for senescence or maturing. Clearly, we could not use the "individual" as our unit. We had to work with the family as our "unity." This is not merely a practical desideratum: it is a biological concept of fundamental importance.

So our laboratory is peopled with families. No individual can join without his family. Hence the subscription for membership is a family one, the same whether for a young couple just married or for the mother and father with any number of children. Before the war it was one shilling per week per family: since the war and at the express desire of the families, two shillings per week per family. This sum is low enough not to exclude a family with a low wage from membership.

Natural Stimuli to Growth

What does this family membership mean in equipping the club? There must be equipment affording opportunity for action for people of all ages—for the infant, the under fives, the school child, the adolescent; as well as for parents, whether young or old. Still more important in a building planned for free circulation everywhere, it means that all ages mix and mingle throughout the club—just in fact as people do at home.

I understand from what I have heard and read of American life

that such a situation would be highly unusual. I gather that with you there is a great gulf set between the activities of parents and that of their adolescent children. Let me tell you of what happened in our experiment. For the first ten months, parents, with their infants and their school children, used the Centre freely. The adolescents could be seen putting their head round the door ". . . Mum and Dad's there: come on—let's get out of this." Apart from their attendance at their health overhaul—a condition of family membership—they were seldom seen. Only as the membership grew to 500—600 families and the grown-ups began to do things—particularly the young married folk—did it become a desirable place to the adolescent. Now he put his head round the door ". . . Come on, it's all right, Mum and Dad's playing whist." From that time they came in numbers which represented their statistical proportion in society. They were shy, and they were awkward or boisterous in their social inco-ordination. But they were within sight of and in contact with that very desirable "big fellow." Result: they wanted to emulate the big fellow, and spontaneously began to modify their actions; and in doing so they had unconsciously moved into the next stage of maturity. **This process of being naturally drawn to further maturity through continual contact with the slightly more mature, appears to have general validity in society.** Just as the young adolescent wants to be like the older adolescent, so the older adolescent is subtly affected by those in the serious courting stage; the courting couple grow an interest in the newly married. Perhaps the most marked example of the effect of contact with the more mature was to be seen in the young married folk. They often joined announcing that they wished to have no children or no more children. Within 2½ years this desire had been reversed. They now, often shyly, announced that they wanted to have a child, or another child. It is important to note that there had been no increase in their wages, no improvement in their inadequate housing accommodation. What had released the natural urge to a further maturity? The sight of other families **enjoying** having children; the enviable sight of other families widening their field of social excursion in the process; penetrating further into and understanding more fully their environment in the course of the natural growth of the family. **Health, like disease, is infectious—given the conditions in which its infectivity can operate.**

Pregnancy, a Developmental Process

There were in the Centre special circumstances which made

this a possibility. Interested as we are in growth and development, we keep in closest contact with the family throughout each important phase of parenthood as it occurs. So when a family is pregnant, the wife is re-overhauled and during the whole period of pregnancy the greatest attention is given to nutrition* and to the maintenance of all the bodily reserves, as well as to their mobilisation through her continued, if not enhanced activity, during pregnancy. This seems natural to the family, for in parental consultations occurring at each significant stage in parenthood they come to regard pregnancy as a natural process—one of ease, not of disease—and one through which they, as parents, can reach out to their own full maturity. So both of them assured that everything is in order, assured of the great capacity of the latent reserves now being called into action, confidently and with zest the wife now continues all her activities and interests. She swims, she plays badminton, goes to keep fit. Indeed, to their surprise both parents find that through their very pregnancy they are being led further and deeper into their social environment. They meet others also about to have, or having just had, a baby and out of common interests, friendships grow. Now this is only possible because of the family orientation of the Centre, and because of the possibility for continuity in its many sided day to day contacts. Here mothers may meet over the making of a layette or with their children in the afternoon; in the evenings husbands are introduced and families mingle. Where at a parental consultation courage may have seemed lacking and understanding not complete, either or both may be engendered by the actions, the understanding and the experience of other families. Gossip and seeing what others do, are fruitful methods of infection with both these qualities, courage and understanding. The Centre is a place where gossip tends to lose its idle character and become a vector of topical education. Knowledge spread in this way has the advantage of being transmitted in the vernacular. It becomes part of the idiom of the people. It hits them at the time when their "ears are open" and when they can forthwith USE it—this is an example of what we have defined as—topical family education.

So pregnancy proceeds. Two days before delivery the wife is swimming in the pool, two hours before she goes to hospital she is in the cafeteria with her friends; forty-eight hours later she is back at home with her baby, visited daily by the Centre midwife.

*In order to secure food of known quality and freshness the Centre has a farm as an integral part of its equipment, the produce of which is primarily used for pregnant families and their children under 5 years of age.

There is the minimum disassociation from husband and home. She gets up directly she is ready to do so and attends to her own child. They bring it as early as possible to the Centre for its first overhaul, and for a further parental consultation. Here they find out all they can of how the baby is growing, and come to recognise the meaning of the new orientation its presence is bringing about within their family circle. So they carry on till the time of weaning approaches—time for the next parental consultation . . .

So greatly and so quickly did the families appreciate these circumstances that by the end of 2½ years in the Centre we had young people coming to ask if they could have their next health overhaul put forward so they could be as fit as possible by the date of their summer holiday when they hoped to start a baby. We had with quite unexpected rapidity reached the hygienists' dream—of parents voluntarily seeking to free themselves from disorder before conception occurs.

The "Temporary" Member

In the Centre we go further. I have said that only families are eligible as members. To that rule there is one exception. The grown-up son or daughter of a member family is allowed to introduce a boy or girl friend as a temporary member. The temporary members have full use of the social activities in the Centre though they do not have the privilege of periodic health overhaul. In this way the young people acquire a far fuller range of opportunity than they would otherwise have, of doing things together and with others, within the setting of a mixed society of all ages during the years that they are moving slowly towards the discretionate choice of a mate. When a final choice is made and marriage is in view, each then has the privilege of overhaul followed by a joint pre-marital consultation. So we have moved toward the eugenists' dream also; easy, diverse, and graded contacts for selection of a mate, within a mixed society, **with knowledge of the significance of marriage as marriage is approached and the full advantage of medical science to diagnose and to eliminate disorders before wedding.**

Conditions Promoting Growth & Development

All this sounds perhaps a little facile. Why if it is so apparently easy, do we not see the unfolding of living energy more frequently in our own families, in our friends, and in our social set ups? One of the features of living organisms is the possibility of arrested growth. If circumstances are not favourable existence

continues, but growth and development are not manifested. The circumstances for full growth and development have not been present in ordinary life in our metropolis.

What then were the circumstances peculiar to the Peckham Experiment? I have already mentioned several of these. **First,** the family orientation of the Club with its corollary of a society consisting of all ages mixing freely in their association and in the use of all material. **Second,** the periodic health overhaul by means of which all eradicable disorder is removable from the outset. **Third,** is the easy contact between biologist and members, so that the family is able to take such information as it can make use of at the time when it is ready to embody it in its daily life and actions. As one member said, "I've been thinking, Doctor—we've got a swimming pool downstairs and to enjoy it we've got to learn to swim—upstairs we've got a pool of knowledge and like the swimming pool, to enjoy it we have got to learn to swim in that too."

But there are other salient factors in the Centre which allow life to go forward in ease and order rather than disease and disorder. In the Centre there is material for action of every sort, set out in such a way that it is visible to all. We postulated that the sight of action would prove to be the natural stimulus to action. This we have found to be the case, but with certain modifications. It is taken for granted by the educator and by the social organiser that the sight of expert achievement is the stimulus to achievement. We find this to be the case for the small number who know what they want to do, and who have some capacity, however small, for doing it: a mere 10% or less of the populace. What of the 90% of the adult population who do not particularly want to do anything and who have little skill or accomplishment? For them the natural stimulus is the sight of someone less competent than themselves doing something they feel they could do as well, or better. The wife of 40 who since marriage has foregone all physical activity other than her housework, sitting by the window of the swimming pool is heard to say to her husband, "Jim, look at her—she must be ten years older than me, and with that figure too! I don't see why I shouldn't go swimming." A week later she appears in the swimming pool.

The significant observation to be made here is that it takes contact with all sorts to provide the natural stimulus to action. Had the only swimmers all been experts, the swimmers would form a select and progressively exclusive group, surrounded by a crowd of spectators—as we see on our playing fields and in any

of our best equipped community centres. The cult of the expert within the community engenders social aloofness and militates against participation of the people as a whole in social action. Moreover non-participation to any degree at all ultimately means non-critical and invalid spectatorship.

The fact that the families are of varying wage, education, social class and skill means that there is within sight and knowledge of every family a great diversity of experience. This enables us to dispense with leaders, teachers, experts and professionals and organisers. In the Centre there are none of these; there is only material there for the use of all its members. The absence of all instructors, leaders or organisers is an unusual circumstance pertaining in the Centre. Members can do what they like, when they like, how they like and with whom they like. As they use this material they discover others who want to use it too. That leads to getting together to find how to arrange that each can have his use of it and all be satisfied. That very necessity leads to an awareness of the "other." A very different inference would be tacitly drawn if an organiser were to step in and formulate a programme. Each individual then would be confirmed in the insistence upon his rights set against an anonymous "other" or "others." The sense of wholeness would be undone, rather than enhanced, and separatedness perpetuated.

Significance of Mixed Society

It will be readily be seen from what I have said that were the group of families to be drawn from one class, one wage level, one type of industry, or to be one grade of education, the foci of stimulus to be found within the group might well be too limited to evoke anything like full function in the family. In choosing Peckham as our locality, it was this very possibility we had in mind. Peckham was a residential area where there were, congregated within a square mile, families with a very wide diversity of culture, wage, occupation. We had calculated that 2,000 such families, i.e., 10,000 individuals, would give us one or two good musicians, one or two actors, one or two good footballers, and so on, who by taking advantage of the material available to them in the Centre would inject their enthusiasm into the families gathered there. Were we to have chosen for example a new housing estate where there were housed people of one class, one type of skill, we should have needed a Centre to accommodate 100,000 individuals to ensure a diversity of interest within the group. In the absence of such diversity what could be done but to introduce such interests

through the services of organisers and leaders? But in doing so we should have dammed back the springs of spontaneity and initiative—foreshortened growth and predetermined social action.

By segregation of people into social and economic strata as we have been doing since the industrial revolution, we are quelling the natural flow of living, robbing all classes of the natural stimulus of discretionate action, making impossible the natural "infectivity" of health—destroying the "wholeness" of society. In so doing it may well prove that, to cope with the absence of these very qualities vitality and discretionate action in society, we are saddling the future with a burden of health and educational administration that may well prove too heavy to be borne. In social life we are in fact doing much the same as we are doing to the sources of human food—first process out the vital quality and then proceed to administer as a drug (sic) "vital" elements in artificial form.

Man does not live by bread alone but by all that he can take from the endless diversity of his environment. If there is insufficient diversity he will suffer a fractional starvation of his personality. He will retire and encyst himself, or he will break out and disrupt the social environment. In either case the springs of action are quelled and ordered living is inhibited.

But as the social worker only too well knows, every degree of both these reactions exist in society—quenching the flow and disturbing the emergent energy that, suffusing the family, should lead to the fullness of living.

Unlike the sources of physical energy, coal, petroleum, water power, found in vast deposits, living energy is disperse. It is distributed in small unities—"families." Scattered throughout the social matrix it is families that emit biological energy like nuclei of cells within the body tissue. If something is faulty in the function of each nucleus, if the living energy cannot flow freely from family to family, i.e. from home to home, then there can be no cohesion, no strength, and no power in society—no "organisation" in the biological sense, however great the systemisation, now however intense the planning.

The seed of social order is the Family. **If we wish to "grow" health we must cultivate the soil of environment through which the family must feed to function.** This is the first natural law that has grown out of our study of human biology. That given favourable circumstances "energy" is evolved through the family, has been demonstrated beyond question in the Centre. We have seen

that this energy, given freedom of action as one of the favourable circumstances, **will quicken a group of families leading them to orientate their living on a mutual basis to the advantage of all.** In biology the correct term for this is "organise":—take shape, form organs which, through growth, become co-ordinated—by which we mean the manifestation of a spontaneous order in their living.

To a biologist this is no surprising finding—for he knows that there is no "leader" sealed up within the egg to direct the growing chick. **Order is immanent** in all biological material. But biological material has to wait on circumstance for its urgent unfolding.

THE PROBLEM OF VALUES IN THE LIGHT OF PSYCHOPATHOLOGY*

ANTON T. BOISEN, D.D., CHAPLAIN EMERITUS
ELGIN STATE HOSPITAL
ELGIN, ILINOIS

ABSTRACT

A study of the ethical and religious factors in 176 cases of dementia praecox in the Worcester State Hospital indicates that moral self-judgment is among the most important causative factors. This is shown in the case of a patient who in his acutely disturbed period was occupied with the idea of effecting a reconciliation between God and Satan. The standards by which this man judged himself appear to have been functions of his social relationships, particularly to those whom he accounted supremely worthy of love and honor. Like the others in this group he was one of those who accept the standards implanted by their early guides and have succeeded neither in conforming to them nor in growing into a larger loyalty or a more comprehensive understanding. His religious concern was associated with his attempt to face his difficulties and to bring himself into accord with those loyalties and to realize those values which he felt to be of cosmic importance.

Nowhere better than in a mental hospital do we have opportunity to examine into the emotional and volitional springs of human behavior and the standards of moral judgment. In the majority of cases which come to us each year the causative factors are not to be found in demonstrable organic disease. The difficulty is rather one of emotion and volition, of belief and attitude. We are dealing with individuals whose behavior is guided and controlled by certain desires and value judgments. And we see these individuals breaking or broken under the stresses and strains of love and hate and fear and anger. We see them grappling with the issues of spiritual life and death, of survival and destruction; and we are able to observe the end results of the diverse ways in which individuals deal with failure to measure up to the moral standards which they have accepted as their own. In these end results we see in exaggerated form processes which are present in health together with their logical outcome. If, therefore, we have eyes to see and wisdom to interpret, we may be able to discover the laws which have to do with the attainment of the moral objectives of particular individuals. We may be able to throw some light upon the factors which enter into the determination of these objectives and of their associated hierarchy of values. And we may be able to draw some conclusions in regard to the social implications and consequences of different types of moral objectives and ethical system.

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A particular case may serve as an illustration and point of departure for some generalizations concerning the problem of values which have been arrived at through the study of the religious and ethical factors in 176 cases under investigation in the Neuroendocrine Research in Dementia Praecox, which has been under way during the past five years at the Worcester State Hospital under the direction of Dr. Roy G. Hoskins of the Harvard Medical School.

James G., a grocery clerk of 29 years, with 9th grade education, fair intelligence, good physique, and without demonstrable organic pathology, was brought to the hospital in an acutely disturbed condition. From the patient himself and from his relatives, the following facts were learned regarding his life. He was born in the home of a Southern clergyman who died when he was twelve years old. As a young boy he had certain difficulties in learning to manage his sex drive. At the age of sixteen he left home without having reached any solution of this problem and fared forth into the great world, finally landing in the army. Here he stayed nine years, making a fairly good record and serving most of the time as a non-commissioned officer. In the army, along with a majority of his mates, he found an outlet for the troublesome sex drive by going to houses of prostitution. Supported thus by group opinion, he was quite comfortable about his manner of life, especially in view of the fact that he was always careful to report after any indulgence and get his prophylactic treatment and the protection against disease which this insured. At the end of the nine years he married and, in due course of time, a child arrived. With the birth of the child came a mental disturbance, something which sometimes happens to fathers as well as to mothers. To use his own words, there was "something funny about the way his child was born." A million things were passing through his head. He was under a spell of fear. He felt that he had a lot of responsibility, but he wasn't thinking so much about the baby. He was thinking about human nature and its mechanisms. He was trying to understand what was the cause of all emotion and he wrote an article expounding his theory of the human emotions. This he sent to a local newspaper and he took great satisfaction in the fact that it was published.

This disturbance gradually subsided and he remained well until things began to go wrong with him economically. He set up in business for himself and was burnt out. He obtained and lost several jobs, and he became involved in debt. Then he broke men-

tally, and once more, as at the time of the birth of his child, he became concerned about cosmic affairs. When he came to the hospital he told the following story:

How did it start? I hardly know. I think it was the smell of the fish. I had dreams of crawling along the bottom of the sea among the fish and the oysters and everything. I had to give up work and sit around and brood. Then ideas came to me. I didn't have to search for words. It was just as if I had been commanded to say certain words I had never heard of before. I had a vision and it seemed to me that I could see way back to the beginning of all creation. I could see the evolution of man up to his present being. And then it came to me that from the beginning of the world there have been two rulers over the peoples of the world, God and Satan. One was just as powerful as the other. It seemed to me that a greater effort should be made so that both should become one. God should be brought to meet Satan and then Satan could go and teach the people the right. Of course this would take years and years. It was to be my job to start it and to get the spirit working. It was my vision that in time all humanity would love absolutely and perfectly and without any nourishment and that God intended all people to be just one living piece of humanity. The Church would continue but it would have to draw under one heading, that is, under the teachings. Yes, of course, that will be what I call the millennium, that is, all humanity striving for one goal and for the kingdom of heaven.

You see it has always been my nature to do right. There has been a lot of talk about this thing and that thing, about the farm problem and so on. It was my idea that I could see no earthly reason for some of these animals that were roaming around in the forests preying on the domesticated animals. I thought it would be just the thing to go back to the jungles and clean up the snakes and the reptiles and the alligators.

Yes, I have always been a thinker. I have read about some of our famous characters. I have also read fiction and vice and have indulged in all the little things of life. I have always been a double personality. I have had two consciences.

You see, I interpret it that there has always been a battle between the two for supremacy. I could see no earthly reason why such a conflict should be kept up. I didn't see why the Lord intended that people should be always and forever fighting each other. Thinking it was the true light of God, it seemed to me that in some way I might bring this to Satan's attention so that he could bring all his following into the light. It is my belief that people of the Protestant faith—well, I must bring it back to myself. I am the true spirit of God and the product of the earliest stages of man after it was evolved from the seas. When I was in the rage, there was something telling me that I was the true spirit of Christ.

Rather a grotesque set of ideas! And yet they are thoroughly typical of such disturbances. They also have a meaning and the task of the psychiatrist, in the words of Dr. Adolph Meyer, is to discover the sense in the nonsense.

For the purposes of this study the first thing to notice is the marked religious concern which this patient showed. Each of the two disturbances began with the sense of mystery. It was the idea that there was something strange about the way his baby was born which set his mind running and jumping. And in the second disturbance, ideas came to him which he had never heard of before and with which he seemed to have nothing to do. We notice that he goes on to concern imself with cosmic affairs and that he personalizes the force which he conceives to be in control. This is thoroughly characteristic of the acute disturbances and upheavals.[1] They begin almost invariably with an eruption of the lower strata of consciousness which is interpreted as a manifestation of the superpersonal. To the individual concerned the effect is overwhelming. It shatters the foundations of his entire mental structure. It sweeps him away from his moorings out into the uncharted seas to the unknown lands of the inner world. He is no longer concerned about the merely individual but about the cosmic and the universal. And very commonly he thinks of himself as in a central role in the cosmic drama. Such experiences are as old as the human race. Their destructive effects led to the ancient question, "Can a man see God and live?" But their effects are not wholly destructive. They seem rather analogous to fever or inflammation in the physical organism. They may be regarded as attempts at reorganization in which the entire personality, down to the profoundest depths of the subconscious, is aroused and its forces marshaled to meet a

[1]In the 176 cases studied in connection with the Neuro-endocrine Research in Dementia Praecox at the Worcester State Hospital, the percentage distribution according to types of onset and characteristic ideation is as follows:

Type of Onset	Characteristic Ideas						
	Sense of Peril			Ideas of Self			
	Cosmic Catastrophe	Death Accepted	Death Resisted	Cosmic Identification	Mission	Rebirth	Absent
Acute (54 cases)	54	63	15	50	13	19	13
Subacute (70 cases)	36	37	17	36	23	19	24
Insidious (52 cases)	4	2	13	2	2	0	77

Of those who had ideas of cosmic identification, there were 12 who identified themselves with Christ, 10 with God, 2 with the sun. The rest were undefined.

crisis situation. Our figures show that these emotional upheavals make for change either for the better or for the worse. In contrast to the cases characterized by a gradual onset and by a lesser degree of disturbance, the acute disturbances show a large proportion which go out of the hospital completely recovered or else find their way to the back wards as hopeless wrecks.[2] The authoritative "Thus saith the Lord" of the old Hebrew prophets together with their frequent references to the coming day of doom suggests that they may have shared this experience. And men of such outstanding religious genius as John Bunyan and George Fox, Emanuel Swedenborg, and Saul of Tarsus seem to belong in the same group. These men, together with other great mystics, have passed through searching inner experiences in which they have found the end and meaning of their lives.

Such experiences have been variously accounted for.[3] The individuals themselves who pass through such experiences agree in feeling themselves in touch with some mighty personal force to which generally they give the name of God. From the standpoint of this study the important point is the terrific impact of the experience with which the disturbance begins and the tendency to personalize the forces which seem to be involved. When we see the results of such experiences in lives destroyed or in lives made over and sent forth sometimes into new and creative work, the suggestion comes that, of all human desires, the deepest and most fundamental is that for response and approval by that social something which is symbolized in the term, God, and that this fact has important implications for the social sciences as well as for psy-

[2]In our Neuro-endocrine Research cases, the percentage distribution according to type of onset and present condition is as follows:

Type of Onset	Present Condition						
	At Home			In Hospital			
	Social Recovery	Improved	Unimproved	Institutional Social Adjustment	Institutional Adjustment	Unadjusted	Temporary Recovery and Setback
Acute (54 cases)	13	7	2	18	35	16	9
Subacute (70 cases)	6	7	4	21	42	16	4
Insidious (52 cases)	0	9	15	24	31	21	0

[3]Cf. Freud, *Psychoanalytische Bemerkungen ueber einen autobiographisch beschriebenen Fall von Paranoia,* Neurosenlehre. Vol. III, s. 258; Sullivan, "Conservative and Malignant Features of Schizophrenia," *American Journal of Psychiatry,* January, 1924; Jung, *Two Essays in Analytical Psychology,* New York: Dodd Mead & Co., 1928.

chiatry and psychology. These implications may become apparent when we consider the significance of our patient's interesting proposal to bring about an understanding between God and Satan.

In reviewing our patient's history, we may notice first of all that he was born and reared in a religious home. His father was a clergyman of the conservative type and his mother a devoted church worker. From childhood on, as he says, it had always been his nature to do right. That is, he accepted without question the teachings of his parents and of the church to which they belonged. But he had also been a "double personality." This means that, while he wanted to conform to the parental teachings, he found within himself certain difficulties which he was unable to resolve in accordance with the accepted standards. At the age of sixteen he left home and, after a short period of wandering, he enlisted in the army. He not only put on the uniform but with it he accepted also its easier standards of sex morality. Supported now by the group and its attitudes he was able to give expression to the troublesome sex drive and to be quite frank and comfortable about it. He seemed to have made a real adjustment. But, with his marriage and then with the birth of his child, the situation changed. It was no longer sufficient for him to feel himself a member of the army group. The responsibilities of parenthood identified him once more with his own father and with his other early guides and their teachings. He begins now to think of his father's God, the symbol of the group ideal, whose authority he had never questioned but from which he had run away. It is quite clear that, measured by the standards of his father and of his father's God, he would be weighed and found wanting.

But our patient had already socialized his inner conflict. He had identified himself with the army group and he believed in this group and in its ways of looking at things. Their standards were, of course, easier standards, standards which for him represented a concession to his own weaknesses. This being the case, it is obvious that Satan is for him the symbol of the army and its code of sex morality. But his army mates were good fellows after all and he was one of them. Hence, his proposed solution. He must try to bring about an understanding between the symbolic representatives of the two groups with which he had been identified. He is to go and see God and get God to come and meet Satan in order that Satan may be converted and bring all his following into the light.

This suggestion may not be so funny as at first it seems. It is to be noted that he got well and that he has now been for five years out of the hospital, apparently in excellent condition. He seems to have succeeded in bringing about some sort of working agreement between the conflicting elements in his own personality. It is also to be noted that the proposal seems to be rather in line with the teachings of psychoanalysis and of the mental hygiene movement. It is quite likely that our patient's father and his other early guides may have been oversevere and puritanical in the matter of sex morality. And it is hardly to be questioned that organized religion has much to learn about human nature and about the more enlightened ways of managing the powerful sex urge. But the point for us to notice is that this man's standards were determined by the group with which he was seeking identification and whose approval he therefore needed. His primary loyalty had been to his parents and the other early guides upon whom he had been dependent for support and affection and whose composite impress had become represented in his idea of God. Failing to measure up to the standards taken over from these early guides, he had made a temporary adjustment by taking refuge with a group whose sex morality was not determined by the motive of race perpetuation. The conflict was precipitated by the experience of fatherhood, which brought to the fore the motive of race perpetuation and therefore required reconciliation with that in his social experience which, for him, represented the abiding and the universal.

In a previous article,[4] I have attempted to give an interpretation of the different types of personality disorder and maladjustment in the light of group psychology. I have there sought to show that the mentally disordered individual is one who, by standards which he has accepted as his own, stands condemned to such an extent that he is unable to bring himself before the inner bar of judgment. He cannot bear the thought that those whom he counts supremely worthy of love and honor should know him as he is. He thus becomes isolated from those with whom he is seeking identification and whose approval he wants. His battle is being fought out within. The true delinquent and the criminal, on the other hand, is one whose imagination has never been kindled by any commanding ideal and who has refused to accept for himself the primary loyalty to his early guides and the ethical standards

[4] "The Sense of Isolation in Mental Disorders: Its Religious Significance," *American Journal of Sociology*, XXXIII (1928), 555-67.

which they have sought to implant. Instead he has taken refuge in some gang with ideals and with a code of its own. The thief must belong to some group and have some sense of honor in order to escape psychosis. It seems safe to say that no man will have a psychosis so long as he can belong to some group whose standards he can accept as final; and this fact accounts for many of our important group phenomena. There are multitudes of men and women who, like our patient, attempt to solve their sense of moral failure by identifying themselves with groups of easy standards. The average, or "normal," man is thus apt to seek the solution of his conflicts by socializing them with a somewhat lowered conscience threshold and comforting himself by the thought that he is no worse than his neighbor. And even the Church, the institution which stands for that which is held to be permanent and universal in human society, tends constantly to introduce short-cuts and protective devices in order to bolster up the moral self-respect of its members. It becomes overparticular about creedal conformity or ritualistic niceties and in other ways tends to substitute minor for major virtues and loyalties. Our patient is therefore not alone in trying to get God to come and meet Satan. He is merely giving expression to the common tendency to seek divine sanction and approval for compromises made in the interests of human frailty. There is thus constant interaction between the needs and the frailties of the individual and the standards and ideals of the group. The individual judges himself by the standards of the person or group with whom he is seeking identification, and to be unable to bring himself before the inner bar of judgment means for him isolation and destruction. For the sake of his own mental health he must belong to some group; and his frailties may lead him either to shift his loyalties to a group of easier standards or else to join with others in modifying the exacting requirements of the group to which he may belong through the accident of birth and early influences. The presence of the protective devices with which organized religion is so encumbered means simply that the church is made up in large part of individuals who are not ready to meet the conditions of growth.

Our ethical standards and ideals are therefore determined by our personal and group loyalties. Freud and his followers are quite right in insisting upon the importance of the early influences. The father, the mother, the early guide stand to the small child as embodiments of that in the Universe upon which he is dependent for support and affection, and that in a way and to a degree which

is never repeated in the course of his development. The impress of their influence therefore goes with him throughout his life and implants in him ideals and standards from which there is no escape except through growth into a larger loyalty and a more comprehensive understanding. This is seen very clearly in the case of our patient. He has recognized and accepted the parental ideals and standards, but he has found difficulty in measuring up to them. He has therefore followed the line of least resistance and has sought to escape from them by taking refuge in a group of easy standards. Even though he succeeds thus in finding social support and approval for the indulgence of his unmanageable sex drive, he still feels the superior claim of the parental group and its ideals. He has not grown into a larger loyalty or into a more comprehensive understanding. He has merely made a concession to his weaknesses. He is, therefore, a divided personality. In such cases Alexander is quite right in talking about an "unconscious super-ego" which is distinct from the "conscious conscience" or "ego ideal."[5] Such a cleavage is however pathological. It is this which constitutes the "divided self," which Professor James has so brilliantly described.[6] It is this which made our patient subject to the catastrophe which befell him. He had identified himself with the army group and outwardly accepted its standards without giving up his allegiance to the family group and to the ideals implanted in his early training. The coming of the child, together with the blocking of the outflow of energy through vocational thwarting, brought him face to face with his primary loyalty. This meant for him a day of judgment. But such a cleavage should not exist in the healthy personality. In any healthy development the implanted loyalties and ideals are assimilated and embodied in the expanding personality with a constant outreach after the best and the true which may result in an outgrowing of the early ideals. It may be said that the entire social structure, internalized in the form of conscience, is built on a principle which forbids the disregard or evasion of a primary loyalty but which does permit that primary loyalty to be incorporated in a loyalty more comprehensive. According to this view, then, the Freudians are right in emphasizing the importance of parental influence in the formation of ideals and standards. Just as truly as the child receives from his parents a physical structure, so also does he take over from his early environment a mental structure organized around his primary loyalties. But the ethical ideals and standards which are thus im-

[5]Franz Alexander, *Psycho-analysis of the Total Personality*, pp. 20 ff.
[6]William James, *Varieties of Religious Experience, Lectures* VI-VIII.

planted are not fixed and rigid except perhaps in pathological cases. Conscience is not just backward-looking but, as Hocking expresses it, it lies on the growing edge of human nature. It represents the awareness of success or failure in maintaining one's status and one's growth.[7] It is the artistic sense which tells us what is or is not fitting in social relationships long before our clumsy reasons are able to pronounce judgment. And the ideals and standards by which we judge ourselves are determined, not so much by the group to which we have belonged as by that to which we aspire, not so much by the yesterdays as by the tomorrows.

The concern about cosmic affairs and the tendency to personalize the cosmic forces manifested by our patient is characteristic of those disturbances which represent awareness of danger and attempts at reconstruction. It is not characteristic of those cases in which the patient drifts unresistingly down to destruction or in which he attempts to conceal the situation.[8] This is equivalent to saying that in the first type we have religious concern and in the others we do not. We are thus justified in saying that religious concern tends to appear wherever men are facing their difficulties and seeking to become better. The religious attitude may be characterized by the outreach after the best and the true and by the attempt to elevate the personal and group loyalties to a cosmic level and make them something more than contemporary and local. Religion is thus social in origin and it seeks to meet the need for social response and security in the attempt to identify the individual self with that which is felt to be universal and abiding in human society. The personalization of this conception in the idea of God is a consequence not merely of the social origin of religion but also of the need of the struggling individual for social support and for relief from the sense of isolation. Because of the social utility and therapeutic value of the belief in a personal God it seems very doubtful if a purely humanistic religion can ever make any headway outside of University centers.

In our patient's commission to "get the spirit working" and in his desire to enlist Satan in the task of bringing all men into the light we see an expression of the missionary motive which is commonly characteristic of vital religion. This may be regarded as the reverse side of the motive which prompts the delinquent to seek refuge in a gang. Just as the delinquent seeks social valida-

[7]Hocking, *Human Nature and Its Re-making*, pp. 123-24.
[8]Cf., footnote 1; also Boisen, "Psychiatric Approach to the Study of Religion," *Religious Education*, March, 1928.

tion for his antisocial tendencies, so the individual, who is reaching out after the best, seeks to share any new insights which may have come to him and to enlarge his circle of influence. This impulse may be regarded as the root of all organized religion and a necessary consequence of the attempt to elevate one's loyalties to the cosmic level. Organized religion is thus the attempt to provide for the perpetuation and extension of the profounder insights and the moral achievements of the race and for the co-operative pursuit of the better personal and social life on the basis of an accepted ideal toward which we are moving and of its concomitant hierarchy of values.

We see, thus, in the case of our patient, that the problem of values is very closely associated with the problem of religion. In his religion we see the attempt to raise his loyalties and his value judgments to the level of the cosmic. In his idea of God we see the symbol with which is associated the thought of those whom he counts most worthy of love and honor and which represents to him that in his social life which he feels to be abiding and universal. The idea of God thus represents to him that which is supreme in his hierarchy of loyalties. It represents the composite image of those whose fellowship and approval he seeks. He therefore judges himself by the standards which are imposed by his religion and associated with his idea of God. In thus relating the problem of values to that of religion, it must be admitted that we are recognizing its personal and subjective nature. Our religion and the ethical ideals and standards which it represents are subject to the accidents of birth and early influences and to personal affinities and choices. All this is true. But it is also true that religion stands for the earnest outreach after the true and after the best in our social relationships. On the basis of clinical observations, it may be asserted that no individual is likely to remain permanently satisfied with a loyalty which is for him a lesser one and that protective devices and subterfuges which block growth are seldom effective. Inner unrest and social maladjustment almost invariably result. In the fact that there seems, thus, to be no escape from the primary loyalties and the ideals and ethical standards which they have inculcated, except through growth into a higher loyalty and a more comprehensive understanding, we may find the basis for a synthesis of the conflicting loyalties and differing standards. In the enduring and inexorable quest, not of the good—a formula which implies a fixed code and a static morality—but of the best—a formula which implies relativity and

provides for continuous growth—we are pointed toward what our patient calls, "the millenium, when all men shall be striving together for one goal and for the kingdom of heaven."

It is perhaps not wholly accidental that, out of a personal problem with an unmanageable sex drive, our patient has thus been led to concern himself with the problem of world peace. Chance may have had something to do with his enlisting in the army, where he had ample opportunity to become aware of the unhappy state of this sick old world in which "men are always and forever fighting each other." But the problem of loyalties and values which was responsible for his personal conflicts is not without its bearing upon that of war and peace. Conflicting loyalties and diverse standards have in the past been a fruitful source of war and social difficulty, and the tendency toward discord has been greatly accentuated by those who find it much easier to fight for a cause than to live up to their ideals. Many a man who falls far short of his accepted ethical standards and is rather careless about his church attendance will get a glow of righteous satisfaction out of fighting for the Protestant faith in the white nightgown of the K. K. K. Some of the fiercest of wars have been fought in the name of religion, while the super-patriotism so largely responsible for the recent catastrophe seeks ever to give the finality of religion to its own aims.

If any one enters the objection that the problem of values belongs in the field of philosophy rather than in that of science, there is no need to quarrel about words. The point of this paper is that values are functions of man's relationship to his environment and ethical values of his relationship to his social environment, particularly to those persons who are accounted supremely worthy of love and honor. Such being the case, the problem cannot be approached through abstract reasoning but must be approached empirically on the basis of actual observation and inductive reasoning. And no human behavior is likely to throw more light upon this problem than that of individuals who are grappling with the overwhelming sense of moral failure and isolation and are breaking or broken under the strains of emotional crisis.

AMERICAN PROTESTANTISM AND THE PROBLEM OF ALCOHOLISM

HOWARD J. CLINEBELL, PASTOR

THE METHODIST CHURCH

LAKE RONKONKOMA, N. Y.

(The following article is based on the experience of the author over the last two years of research at Columbia University on the problem: "The Religious Approaches to the Problem of Alcoholism." During this time the author has collected, by means of intensive interviewing, detailed case material on seventy-nine alcoholics. Material is drawn from these case histories.)

It is generally agreed among those familiar with the dynamic approach to the problem of alcoholism, that one of the most necessary ingredients of a solution is a changed climate of public thinking and feeling on the problem. Though vitally necessary, this changed climate is exceedingly difficult to achieve. Among the many reasons for this are included the inertia of a person's attitudinal life, and the related fact that the new way of thinking and feeling about alcoholism is emotionally threatening to many insecure people. This latter fact is probably a more formidable barrier to enlightened understanding than the multitude of vociferous dispensers of misinformation on the subject.

The change of climate that is needed might be summarized tentatively and briefly as follows: The present attitude, based on observation of the symptoms of alcoholism, and on the will-power assumptions of the Rationalistic Age, is generally characterized as **voluntaristic, judgmental, moralistic** and **coercive.** This attitude has not only inhibited the understanding of the problem and often blocked effective therapy, but it has been a factor in the etiology of alcoholism. In contrast, the new attitude which is needed might be characterized as one of **the understanding of causes, the acceptance of the alcoholic as a sick person who deserves help,** and **the will to prevention through therapy.**

The influence of the Protestant Church, both as a reflector and as a creator of public attitudes, has been predominantly on the side of the judgmental, the moralistic and the coercive. A number of the alcoholics interviewed by the writer reported encounters with such clerical attitudes as the following: the voluntaristic, "Come on, Joe. Brace up and use a little will power!"; the

coercive, "Why don't you stop drinking so much? Think what you're doing to your fine wife and lovely children"; the moralistic, "Let us pray about your sin," and the rescue mission approach; "Come to Jesus with your sins." Even when such were unverbalized, the alkie often sensed the "You-naughty-boy-you-never-should-have-taken-the-first-drink" attitude on the part of clergymen. For the alcoholic these approaches have proved to be about as effective as they would be if applied in the case of a hand washing compulsion. At best they result in a shift of symptoms; more frequently they result in the loss of working contact with the victim, and an increase in his psychic confusion, pain and isolation.

The chief contributor to the development of the new attitude has been the lay self-help group, Alcoholics Anonymous. It has achieved the recovery of approximately 90,000 alcoholics in the last fifteen years, using principles based on the atttude that the alcoholic is a sick man rather than a moral leper, and providing an accepting fellowship non-existant in society at large.

It would seem, in view of the popular acclaim of the work of A.A., and the splendid way in which church leaders in general have recognized its work and used it as a referral group, that an article such as this would be strictly superfluous. It is certainly true that the indirect educational influence of A.A. and the direct educational work of the Yale Summer School of Alcohol Studies have begun to make a mark on the church's thinking. However, the following should be observed: a questionnaire was recently sent, by the writer, to a select group of 325 ministers of many denominations, chosen because they are in a position to have full knowledge of the facts about alcoholism. There is in the responses a rather strong tendency on the part of many of the clergymen to appropriate certain facts about alcoholism and elements of the A.A. point of view, without substantially altering the essentially moralistic, coercive outlook to which they had been previously committed. In some cases, the moralistic reservations could be said to cancel out the effective meaning of the new insights.

In the light of our knowledge gained from dynamic psychology about how people's basic attitudes change, this is not surprising. Voluntaristic moralism is deeply engrained in our culture. This is evidenced by a survey of attitudes toward alcohol and alcoholism conducted by Prof. John Riley of Rutgers University. (As reported to the Yale Summer School of Alcohol Studies, 1949). A cross sectional sample of the American population involving 35,000 returns was taken. Approximately half those surveyed believed

that the alcoholic could stop drinking if he really wanted to do so. They believed that the alcoholic is selfishly seeking intoxication. This response is not only a confusion of frequent intoxication and alcoholism, but also an indication of our society's emphasis on will power. Another 23% assumed that the alcoholic could not stop because of "weak will power." This is but a variation on the theme. As a social phenomenon, the church naturally reflects this voluntaristic point of view. It has, however, had a responsible part, both historically and currently, in creating and maintaining this social attitude.

At no point in its work has the moralism of American Protestantism been more tragically destructive than in the handling of the problem of alcoholism. How has this operated? First, it has contributed to the alcoholic pattern of development. For the pre-alcoholic the period of "social drinking" (i.e. when he is drinking within the mores of his own group) is characterized by the fact that the effects of alcohol are more rewarding to him than to the normal drinker. As will be shown, this is probably due to the reduction of temporary allaying of what Harry Stack Sullivan calls "basic anxiety," which is experienced as a nagging sense of inadequacy in interpersonal relations. This takes place through the anaesthetic properties of alcohol—i.e. for the developing alcoholic, his liquor is in a sense a pain killer from the beginning.

This pain is caused, not by the drinking per se, as is sometimes assumed by the temperance journals, but by psychic scars resulting from emotional deprivation in the very early years of life. The load of interpersonal anxiety is increased by the painful experiences in the reality situation resulting from drunkenness. The spiraling phenomenon, present in any neurotic condition, is especially obvious in alcoholism. As the original psychic pain increases because of the humiliating experiences with people suffered by the alcoholic, he reorts to his habitual pain killer—more alcohol. The "squirrel cage" referred to by many alcoholics is this drinking to try to overcome the painful effects of previous drinking.

Involved in this "squirrel cage" is the pyramiding fear experienced as the compulsion begins to develop. The alcoholic's first spree against his intention—when he goes into a gin mill to have two beers, and ends up on a three day binge—is a terrifying experience. Being a part of a culture which still holds in large measure to the will-power conception of human behavior, the alcoholic accepts the belief of approximately 75% of the population

—namely, that he could stop if he wanted to. Since his drinking is already compulsive and since he fits into neither of the only two categories of people of which he can conceive—those who are able to use their will power to determine their behavior and those who are insane—he must defend his already weakened sense of worth by a system of rationalizations, projecting the blame for his strange drinking on external factors. Rather than being equipped by cultural attitudes to seek professional help, he is consigned by his internalization of cultural attitudes to the vicious downward spiral of progressive alcoholism. His "alibi system" spirals in his desperate attempt to maintain his grandiose ego-image which is a compensatory device for a basic lack of self-esteem. The grandiose ego-image and alibi system "defend" him from admitting that he needs help. They are one of the reasons why psychotherapists have often regarded alcoholics as almost hopeless. By the time most alcoholics get to the psychotherapist their pain load is so intense and their need for an anaesthetic therefore so all-consuming, that the tension of psychoanalytic experience is intolerable. The majority of those interviewed who sought psychiatric help before entering A.A. seldom went to the therapist "unfortified" by enough liquor to neutralize the beneficial effects of therapy.

Secondly, let us look at the effects of the moralistic, voluntaristic, coercive attitude on fully developed cases of alcoholism. To put it briefly, the usual measures by which society (and the type of clergyman who considers himself the "conscience of the community") attempts to "correct" the alcoholic merely isolates, stigmatizes and increases the anxiety which caused the compulsive drinking in the first place. The behavior of the type of minister mentioned above, even though clothed in a veneer of enlightenment about A.A. and alcoholism, is devoid of real understanding of causes, and therefore probably lacking in the basic compassion and acceptance of the sick so characteristic of the Founder of the church. The situation is well stated in "American Protestantism and Mental Health"*: "Churches have had **too little concern for understanding why** people behave as they do and have been most **relentless in their condemnation** of acts contrary to social standards, with the result that many have responded with intense guilt feelings . . . It seems that the Church could be more effective if it would give due recognition to background experience responsible for present reactions, and make free use of the Christian principle of forgiveness."

*"American Protestantism and Mental Health," Journal of Clinical Pastoral Work, I, 4, Winter 1948, Pp. 1-27.

To illustrate: One of the alcoholics interviewed responded to the question, "What do you feel the church could learn from A.A.?" with the spontaneous reply: "Understanding of the alcoholic. There wouldn't be so many alcoholics if religion had stepped in sooner with less morals and more understanding of causes." A female alcoholic, age 30, in telling why she had never gone to her minister to seek help for her problem, stated the case very pointedly: "I didn't want anyone preaching at me. I didn't feel he had anything to give. He was the fellow who came to our garden parties. You had to be careful not to swear when he was there." A male alcoholic, 36, with a tragic history of neurotic parents, marriages, hospitalizations, jailings and accidents, reported: "I tried to get help from several ministers. Got the brush-off in one way or another. I felt they were saying: 'Get this drunk out of here,' or 'Why don't you repent?' I developed a low opinion of the gentlemen of the cloth." These illustrations give a partial picture; they do not mention the constructive approach based on clinical insight being used by more and more ministers today. They are given for emphasis of the fact that the constructive approach is still the exception rather than the rule. This means that the church's potential resources for health are being used only to a very limited degree. A survey (reported by Dr. E. M. Jellinek at the Yale Summer School of Alcohol Studies, 1949) conducted by Yale University Division of Alcohol Studies, in cooperation with the Federal Council discovered that as many as 50-55,000 alcoholics a year are seen by ministers. It revealed that the minister is often the first person seen by the alcoholic outside the immediate family. As was pointed out by Dr. Jellinek in commenting on this survey, the ministry lacks the equipment in facts and attitudes to exploit this opportunity, generally speaking. Even the minister who is equipped to help the alcoholic is handicapped by the role of moralist with which society and therefore the alcoholic too often endow him. The result, if the alcoholics interviewed are an indicative sample, is that approximately 75% of alcoholics avoid the minister like the plague. Many of those who do go, do so under extreme coercion from a spouse or parent.

It is a rather sad commentary on the church's handling of this problem that A.A. must often apologize for the church's bungling. The following is the report of a 12th Step Call (i.e. two AAs calling on a befogged prospect):

> "Maybe you tried the church. Ed here went back to his church, but he says the preacher didn't seem to savvy

the problem. That's no reflection on organized religion; it's just the way things are."

Hopefully, there are those within the church who feel that the mistakes of the church in this and other human problem areas, are grounds for a serious self-critique on the church's part, and a more serious effort to make amends for past mistakes by registering on the side of the new climate of understanding. This could perhaps take place in the following sequence: (1) the understanding of the psychodynamic causes of alcoholism, leading to (2) an acceptance of the alcoholic as a sick person. As a corollary to this there should arise (3) an emphasis on prevention through therapy, leading to (4) prevention through working toward the correction of the conditions of child raising in a sick culture which makes alcoholism (and every other interpersonal illness) possible. The ingenious moralist whose feeling is reflected in the couplet:

"And, in a torrent if the drunkard sinks,
'Tis not the stream that drowns him, but the drink."*

is guilty of ignoring the most important factor—the violence of the current. Unless the church views the drinking of the alcoholic as a response—however inadequate—to the tragedy of our civilization, her understanding of the problem will be superficial. Lack of real understanding of the **why** of alcoholic behavior, and the resultant futile and frantic attempt to control the symptoms of the disease by means of pledges, moral exhortation and legal restrictions, has rendered the church impotent in many quarters to deal with this issue.

II. The WHY of Alcoholism

Having sketched the development of alcohol addiction in discussing the destructive effects of moralism, let us now elaborate the working hypothesis set forth, and illustrate it with some case material. This hypothesis was that alcoholism is a sickness in the area of ones relationship to people, resulting from serious deprivation of emotional needs in the early years of life. The word "alcoholism" is misleading as a descriptive term since it focuses attention on a symptom rather than on the root disease. Alcoholism does not come in bottles—it comes in people. The alcohol complicates the illness by increasing the painful interpersonal situations, but it does not cause it. The spiraling effect of the

*Quoted from: R. H. Tauney, *The Christian Demand for Social Justice*, N.Y.C. The New American Library, 1949, p. 48.

developing addiction might best be described by Dr. Harry Tiebout's phrase "runaway symptom."

One of the basic revelations of dynamic psychology is that the psychological realm is one in which cause/effect relations operate reliably. A corollary to this is that the causal factors that are in operation during the early and most plastic years of life have a profound and lasting effect on the way a person reacts to situations later in life. In other words, a person's early relationship with significant (need-satisfying) adults has a determining effect on his subsequent relatedness to people and his feelings about himself.

What are those emotional needs or hungers whose deprivation lie at the root of alcoholism? In **New Ways in Discipline, You and Your Child Today** (Whittlesey House, McGraw-Hill Book Co., Inc., N.Y.C.) Dorothy Walter Baruch, a consulting psychologist, describes them as follows:

> "In the first place, there must be **affection,** and lots of it. Real down-to-earth, sincere loving. The kind that carries conviction through body-warmth, through touch, through the good, mellow ring in the voice, through the fond look that says as clearly as words, 'I love you for what you are, beyond any nasty thing you might do. I love you because you are you."

The last two sentences are a psychological description of what in religious language is called "grace."

> "Closely allied with being loved should come the sure knowledge of **belonging,** of **being wanted,** the glow of knowing oneself to be part of some bigger whole . . . our school, our work, our family . . . Every human being needs also to have the nourishment of **pleasure that comes through his senses** . . . The hearty enjoyment of touch and taste and smell. And finally, the realization that the pleasurable sensations of sex can be right and fine . . . Everyone must feel that he is capable of **achievement.** He needs to develop the ultimate conviction, strong within him, that he can do things, that he is adequate to meet life's demands. He needs also that satisfaction of knowing that he can gain from others recognition of what he does . . . And most important, each and everyone of us must have **acceptance** and **understanding."** (pp. 13, 14)

(To say that an alcoholic is one whose basic emotional needs were not met in his early socialization experiences does not separate his

problem from other types of behavorial or neurotic problems. It does not solve the baffling question of symptom choice, but it is a step in the direction of understanding the **why** of alcoholism.)

As a child's psychological needs are met, his own sense of selfhood develops spontaneously. If he experiences the warmth and support of accepting, affectionate, non-exploitative adults, whose acceptance is as free and accessible as the air he breathes, his capacity for self-acceptance develops automatically. If however, his basic needs are not met, the child again reflects the unconscious attitude of the significant adults which he experiences through his deprivation. He feels: "I'm not really worth much, else my needs would be met. Therefore I can't take for granted that anyone will like me." Thus the denial of emotional needs is experienced as rejection, and the child's capacity for what Fromm calls "self love" is seriously impared. Self love or self acceptance is the basis of the individual's ability to love or accept others. Lacking adequate self love, he becomes a person who is unable to relate to others in a mutually fulfilling way. His interpersonal relations are characterized by "basic anxiety." It is this pain that is deadened for the alcoholic by the anaesthetic effects of alcohol.

The pattern of early emotional deprivation was found consistently in the alcoholics interviewed. As is well known, rejection comes in various wrappings: (1) overt rejection of a harsh or cruel parent; (2) the cold rejection of the rigidly authoritarian parent; (3) the better disguised rejection of the parent who attempts to satisfy his own neurotic needs by forcing the child to accept impossibly high standards of success, and thus deny fulfillment of the child's need for achievement; (4) the moralistic parent who makes the child's sense of acceptance by the parent contingent on the fulfillment of perfectionistic standards of conduct, impossible of achievement; (5) the puritanical parent who cripples the child's ability to love by negative attitudes toward his own body and sex; (6) the covert rejection of the overprotective or smother parent, who is attempting to compensate for an underlying inability to give the child real affection. All these forms of rejection could be amply illustrated from the life histories of a group of alcoholics. The types do not normally appear in pure culture, but in various degrees and mixtures.

Mrs. B, Age 33: Illustrative of a combination of the cruel and the puritanial types of rejection. Mrs. B's father was an alcoholic, who was very submissive except after a drinking bout when he became very belligerent. Mrs. B remembers his being brought

home intoxicated, followed by yelling and fighting with her mother. The subject resents the fact that her father never had the courage to defend his children from the beatings of their mother, a drug addict with a very dominating and sadistic character. The mother is described as talking constantly about God and threatening her children with punishment in hell, reform school, jail and the rag man. The mother was so puritanical that she wouldn't allow the girls to learn to swim because she disapproved of bathing suits. As a child, Mrs. B. undressed in the closet because she believed that God couldn't see her there.

Mrs. B. has two sisters who are also alcoholics, and a brother who keeps himself going by drugs. Her childhood was characterized by lack of food and constant tension. Mrs. B. says she can never remember being happy or secure. She has had 4½ years of psychotherapy, and has been in contact with A.A. for 4 years. She has been sober for 3 months due mainly, she reports, to her experience with the Unity Movement, of which she says: "Unity has given me my only hope, my only feeling that there is a reason for being alive." Mrs. B. has been unable to respond favorably to A.A. for any long period of time because of the intensity of her neurosis, which makes every group encounter an agonizing experience for her. Mrs. B. is obviously a very sick person, for whom alcoholism is a secondary matter. The emotional deprivations of her early life amount almost to complete starvation.

The most frequent pattern of parental imbalance of affection seen in the alcoholics interviewed was the domineering authoritarian father and the pampering mother. For example, Mr. D., age 45, three years of post college education. The father was very successful, holding the highest civil service job in his city. He was a strict disciplinarian who demanded respect from his children, and didn't hesitate to hit his son with his fist if he "got smart," even after the son was well along in adult life. The father made sure that the son would go to a local college so that he would be home every night. The mother is described by the subject in glowing terms as "all the wonderful things that have ever been said about a mother put together." She felt that the father was too strict with his discipline and would often intercede, on behalf of the children. The subject is a strict Roman Catholic. He emphasized his adoration of the Mother of God, the Blessed Virgin, conceived without sin. He said: "You pray to her as to your own mother to intercede with your temporal father. This guarantees your entrance into heaven." This case shows how the meaning of

religious symbols is derived from the child's experience with need-satisfying adults. It may be that this combination of parental types if typical of the Irish cultural pattern, has a great deal to do with the truth of the subject's quotation: "You don't have to be Irish to be an alcoholic, but it helps."

Mr. P. is 43, with two years graduate work past college. Twin sisters, 6 years older are the only siblings. One of them is an alcoholic. The subject reports that he has never felt close to his parents. As far back as he can remember in his childhood, there was a three-cornered fight between his father, his mother, and his father's mother who lived with the family. This fight, referred to as "the battle of the homestead," tended to draw the children together. In adult life the siblings are not close emotionally. The father is described as follows: "He never spent any time with us. He took me to a ball game once but he didn't like the idea. He had a bad temper and was temperamental. He was a guy I didn't know —the final discipline when mother couldn't handle things. His attitude toward us was generally harsh." The mother was described as in a constant emotional state caused by the family feud. She developed a "phoney" heart condition in order to win arguments. The subject says of his early life: "I had no home in the sense that you could bring friends there."

Mr. P.'s drinking pattern illustrates two interesting aspects of our problem. First, the onset of compulsive drinking seemed to go with the coming of his first child. He said: "I had great fear of the responsibility of another life." The second is the fact that although his alcoholic pattern was fairly well established three years before he was inducted, he had very little trouble while in the army. It is apparent that for certain types of dependent persons the army authority provides the security of a substitute parent. The subject put it: "We were told what to do." He has been dry in A.A. for 4 years.

The alcoholics interviewed who had experienced rejection in the form of overprotection and success-worshipping parents were the least aware of the damaging effects of their parent's behavior. The cultural tendency to idealize parents and ones early life was very much in evidence. For example, Male #68, the son of a very ambitious and overprotective mother, followed the statement, "I had a perfectly normal childhood" almost in the same breath with "I can't remember ever being without fear of failure and of being hurt physically."

Dr. Baruch points out that "whenever a person is expected to do things which he is actually not able to do, he feels lost. He feels overpowered and small and helpless. Panicky, perhaps and embittered. "I'm incapable. So what's the use?" (p. 15, op. cit.) A case in point, illustrating the frequent combination of over-protection and the projection of extreme goals on a child is that of Mr. M., age 51, a college graduate, only child of a cultured family that was well aware of its name. Mr. M. was not just the only child in the family; he was the sole link of the family line, since neither parent has any brothers or sisters with children to carry on the family tree. The pressure of this responsibility was constant. He was closely guarded at all points. The family had its heart set on the only heir becoming a great doctor, thus to emulate his father who was a very successful physician. The father called his son's attention to how successful the son's grandfather had been. The subject, who has had some psychotherapy and shows considerable insight, puts the situation directly: "Goals and standards were always set for me by my parents. Decisions were always made for me by my parents. I lost heart because I couldn't measure up—everything became distasteful to me. I did only what was necessary." Both parents were disappointed that their son hadn't won a college scholarship (as his father had done) and hadn't become a doctor. This started what the subject termed: "the chain of inadequacy." Twenty years of stomach ulcers and alcoholism resulted. In a speculative mood, M. stated: "Had I grown up differently and had I been allowed to find my level I wouldn't have had the terrific sense of disappointment as early as 21. No matter what I did it was so far short of what they had in mind for me that it didn't seem like achievement at all." The truth of this insight is too clear to need elaboration.

The disastrous effects of pharisaical puritanism on children is illustrated by Mr. K., 47 years old, 8th grade education, youngest child with two older sisters. His father "got religion" in later life and preached it constantly to the boy. The evils of demon rum were drilled into the boy from early years—the father being a candidate for a minor office in the Prohibition Party, and the mother active in the W.C.T.U. At 9 years of age the subject signed a pledge, under emotional pressure, promising that he wouldn't drink until he was 21. The temperance teachings were effective in keeping the subject from drinking until he was 24, but they laid the foundation for revolt. He describes this in these words: "My drinking was a reaction to the restraint of my home—I swung to

the other extreme." The basic cause of the revolt lay in the lack of acceptance and affection by the parents, but the temperance preaching provided the mechanisms of revolt. The parents are described as "self righteous" and "They didn't show me much love." The father who talked so much about religion, frequently beat the son with a razor strap. For example, at age 13 he was soundly thrashed for smoking. He continued to smoke in secret. (In relation to this, it is interesting that having been dry in A.A. for 1 year 10 mo. the subject expresses his intention to give up smoking because, "Christ wouldn't be a smoker." He has returned to all the fervor of his parent's religion, apparently assuaging his unconscious guilt feelings about sex, alcohol and life in general by reverting to the parental pattern.)

The puritanism extended, as would be expected, to the matter of sex. The subject recalls a talk with his father on the subject of masturbation, the main point of which was the warning by the father that the practice would upset him mentally. The early home was filled with constant religious arguments between the Baptist father and the Methodist mother. The atmosphere was such that he reports: "I always wanted to be anyplace but home." The subject's drinking was abnormal from the beginning. Six years after he had his first drink he reports: "I wasn't going anywhere unless I was fortified with liquor. I wouldn't go unless drinks were served there. Drinking had become a part of me. I couldn't conceive of life without it." The subject is one of the few A.A.'s interviewed who does not accept the sickness conception of alcoholism, but puts the whole responsibility on his moral defects—thus assuming the whole load in typical puritanical fashion.

During the series of interviews the declarations: "My father was a self-made man—**very successful!**" and "My parents were **very moral** people" came so frequently as to be almost a refrain. The tragic mistakes of the rigid-schedule-no-spoiling period of child psychology were frequently apparent. For example, Male #40 described his mother by quoting a statement which he remembers her making: "I love my children, but I'm afraid to give them a hug."

Another case in point is that of Mr. L., 40. He has been drinking heavily since the age of 19. He was "on the bum" for 12 years beginning at age 28, and has been hospitalized for alcoholism 13 times. L.'s father was an alcoholic who deserted his wife about the time L. was born, and lived on Skid Rows most

of his life. L. reported having "no feeling" toward his father. L.'s mother was described as "a typical cold tomato," and "I can never remember sitting on her lap like my kids do on mine." The mother's intense hatred for the father is epitomized by the incident in which she wrapped up a dead cat and had L. deliver it to the doorstep of the house where the father was living with a mistress. This hatred undoubtedly left its mark on the child's unconscious.

The regressive nature of alcoholism is seen most clearly in the "bottle babies" of the Bowery who drink themselves into oblivion and wake only long enough to panhandle the price of another quart of "smoke" for more oblivion. Under the influence of alcohol the person is allowed to return to the state of infantile omnipotence—the age in which the child can control his environment by the cry. This fact indicates that the psychic damage responsible for the condition was incurred at a very early level.

Several questions arise at this point: If alcoholism is the result of emotional damage in such an early period, why does it require an average of fifteen years to develop fully? Why is it that many alcoholics seem to live successful lives before they "crossed the line" into alcoholism, and get along well without psychotherapy, once they have joined A.A. and stopped drinking? The answers to both of these questions seem to lie first in the amazing ability of the human character structure to adjust outwardly to even severe psychic pain for long periods of time, barring external crises; and second in the discrepancy between the cultural definition of success and real emotional health. (As evidenced by the quiet desperation of many so-called normal people.) The pain or anxiety producing material may be so skillfully repressed that the person may live for several decades or even his entire life without an eruption. The internal pressures may be touched off by some external crisis, such as the death of a spouse, resulting in the apparently rapid development of compulsive drinking. This happens most frequently in cases in which the person has used alcohol over some period of time as a means of interpersonal adjustment, on a minor scale. Clear distinction should be made in such cases between the precipitating causes and the basic etiological factors.

What about the physiological theories of alcoholism and the possibility that it is a hereditary disease? The high frequency of alcoholic fathers among the cases interviewed might lead one's thought in this direction. There seems to be good evidence that

certain fairly common metabolic and endocrine patterns can be observed in many alcoholics. But as pointed out by Leopold E. Wexberg, M.D., in the March 1950 issue of the **Quarterly Journal of Studies on Alcohol,** there is no conclusive evidence that a physiological pattern found frequently among confirmed alcoholics is not a result of alcoholism, rather than a predisposing factor. There is a possibility that further research in this field may reveal occasional or even consistent physiological factors involved in addiction. An open mind is certainly indicated, but at the present stage of knowledge, the psychological approach seems to be the more productive of useful working hypotheses. Concerning the matter of heredity, Dr. Wexberg states that "there is no evidence that alcoholism is a hereditary disease." That it appears frequently in the children of alcoholics only proves that emotionally warped parents produce emotionally warped children by a process of social transmission.

III. Elements of a Constructive Stand by the Church

What then are the implications of this conception of alcoholism? A. The church could take a firm stand on the scientific fact that the alcoholic is a sick person, and that the sickness results from damage done to the aloholic in the early years of his life, before he was responsible or could defend himself. Such a stand takes the whole issue out of the realm of moralizing. It is tempting for the inherently moralistic person to accept the sickness or symptomatic nature of alcoholism and then twist the conception to fit his purposes—e.g. by calling it "sin sickness" or "It was a sin to a certain point and then it became a sickness." This latter statement ignores both the nature of alcoholism and the entire conception of psychological causation—namely that neurotic people are what they are because of what has happened to them. The moralist who wants to eat his cake and have it too, prefers to admit that the alcoholic (or any other neurotic) is sick, and then he attempts to hold the person responsible for catching the disease. This sort of thinking is still guilty of the fallacy of trying to find alcoholism in a bottle.

The ethical question is not ignored in this formulation of the principle of psychological causation or psychological determinism. One can, for example, hold that Hitler was Hitler because he had certain parents and early experiences, and that St. Francis was St. Francis because he had a different kind of parents, and still believe that the life of St. Francis was ethically superior to that

of Hitler. Alcoholism is an ethical question in the sense that it destroys human values. It is not an ethical question in the voluntaristic or moralistic sense, any more than any other neurosis could be so considered.

A.A. has demonstrated the therapeutic utility of the sickness conception. For the alcoholic, trapped in a culture that is struggling to extricate itself from the voluntarism of the rationalistic age, the conception in A.A. that he has an illness comes as a tremendous release, making his strange behavior intelligible to himself, and reducing his guilt load to a point where recovery can begin. As long as the church in general continues to hold to its moralizing, it contributes to the guilt and self-rejection that causes addictive drinking.

One objection to the conception of the alcoholic as a sick person voiced occasionally by certain of the temperance forces is that this conception gives people an excuse to drink to excess and will result in more alcoholism. These opponents to "making alcoholism respectable" forget two very important factors: First, that if the sickness conception were generally accepted there would be a basis for a unified attitude toward drunkenness. At present it is treated with a nervous mixture of amusement and disgust. The lack of a unified attitude is a contributing factor in the development of alcoholism. The fact that it is considered amusing makes it socially rewarding to a degree that it could not be were it considered as a symptom, possibly, of a socially dangerous disease. If it were commonly recognized that the person who is using alcohol consistently to make social adjustments is moving in the direction of this disease, drunkenness would become less socially rewarding. People do not laugh at a tubercular cough. If alcoholism were accepted as a disease, the public would be concerned rather than disgusted or entertained.

The second factor overlooked by the opponents of the sickness conception is that if the climate of public feeling toward alcoholism were characterized by the sickness conception rather than the moralistic conception, many pre-alcoholics and those in the early stages of the disease would be able to seek and find help before reaching the tragic "bottom." It is the moralistic climate that makes it necessary for an alcoholic to go to the point of complete mental, physical and spiritual bankruptcy before seeking help. The truth of this idea has been demonstrated by the experience of A.A. described below.

B. Prevention Through Therapy: The church has often contended that its job in relation to alcoholism is primarily preventive. This is probably more true since the founding of A.A. and public clinics for alcoholics than it has ever been before. The question arises: What kind of preventive measures are the most effective? In light of the conception of alcoholism set forth herein, it is apparent that many of the so-called preventive measures employed by the church have done little to deal with the basic causes. Let us look at the approach suggested by Dr. Selden D. Bacon of Yale University, embodied in the phrase, "prevention through therapy." When A.A. began it was made up almost entirely of "low bottom" alcoholics—men who had been alcoholics for 10-20 years and who had been consigned to the scrapheap of society by everyone who knew them. As A.A. has become more widespread, an increasing number of "high bottom" alcoholics have come in and responded to the therapy offered—men and women who have never slept in a Skid Row doorway or the alcoholic ward of a city hospital. In other words, as the educational implications of the A.A. sickness conception began to penetrate to people who were just beginning to have trouble with their drinking, they sought help and found it. The next step is the arousal of the interest of large groups of people who aren't alcoholics in any sense, who are now coming to A.A. and to public clinics for advice. As Dr. Bacon has pointed out (in **Federal Probation,** Vol. II, No. 2, 1947): in the same way that the changes in behavior and ideas needed to bring about public sanitation waited until the dramatic cures of Pasteur and Lister, the most effective approach to prevention in the field of alcoholism is through the dramatic therapeutic work of A.A. and the public clinics. These groups are laying the foundation of an understanding of the nature and therapy of alcoholism upon which a realistic preventive effort is being built. The church can be a staunch ally of this effort, helping to build the opinion that will make public treatment facilities more widely possible. Alcoholism is a socially caused problem and therefore a public responsibility. The church can, by helping to change the climate of feeling, make it possible for rehabilitated alcoholics to be reintegrated into the life of the community.

C. Prevention at the Grass Roots: The most urgent need which the church can help meet is therapy and prevention through therapy. From all that has gone before in this discussion, it would follow however that the place where grass roots prevention must ultimately take place is at the point where alcoholism begins—in

the home. By exerting its educational influence in terms of the type of parent-child relationship that will satisfy the emotional needs of the child, the church can cut the roots of alcoholism. This is, of course, a long range program. But it is a program on which the church should keep its eyes. Some within the church will be too impatient to spend the time necessary to deal with basic causes. They will prefer to continue to engage in the less time-consuming business of manipulating symptoms—for example, by attempting to shield people from becoming **compulsive** drinkers by making them **compulsive** non-drinkers.

The church is primarily concerned with making the life of abundance—of full psychological and physical need satisfaction—a reality in the lives of men. If it is successful in its primary task, it will help to deal the death blow to the status of alcoholism as a major area of human tragedy.

FAREWELL AND WELCOME

With this issue, its eighth, completing two full volumes, the JOURNAL OF CLINICAL PASTORAL WORK becomes a collector's item. It was conceived in the mind of its first Editor-in-Chief, the Reverend Robert D. Morris, Chaplain-Supervisor at the Episcopal Hospital in Philadelphia. Its was brought forth in the autumn of 1947 with the personal and financial assistance of all of the Chaplain-Supervisors of the Council for Clinical Training. During its first three years it made irregular appearances, supported by the gratuitous efforts of its contributors, reviewers and editors.

The Journal appeared almost simultaneously with the Journal of Pastoral Care, which was sponsored by the Institute of Pastoral Care of Boston. The two sister periodicals thus explored the professional field of pastoral care together Now, after careful deliberation by the editors and publishers of both, it has been decided to merge them under the title, THE JOURNAL OF PASTORAL CARE.

The new JOURNAL OF PASTORAL CARE will be published by the Council, and sponsored both by the Council and the Institute of Pastoral Care. Directly responsible for it will be the present Editor-in-Chief, the Reverend Ernest E. Bruder, the former editors of the two journals, the Reverends Rollin J. Fairbanks and Robert D. Morris, as Associate Editors, and four editorial consultants. It will continue the volume and number series of the old Journal of Pastoral Care, will appear quarterly as before, with the first issue probably combining several numbers to bring it up to date.

The new Journal will cost three dollars ($3.00) per year, one dollar ($1.00) per copy. Present subscriptions at the old price of two dollars ($2.00) per year will be honored until they expire. The subscription lists of the two present journals will be combined, and those subscribing to both will have their subscriptions extended.

Further information will appear in the pages of the new JOURNAL.

THE MAGIC CLOAK by James Clark Maloney, M.D. 345 pp., The Montrose Press; Wakefield, Massachusetts; 1949; $5.00.

"Most individuals wear a magic cloak. This magic cloak is an assumed investiture with authority which is worn as a mantle of omnipotence. Out of fear of helplessness, in a terror-ridden world, the individual pulls about his shoulders the character of a supreme being. The cloak fits so snugly that sooner or later he is unable to see through his own camouflage."

Thus, with a few strokes of his magic pen, James Clark Maloney begins for us the fascinating study of the magic cloak with which we all defend ourselves, behind which we hide, within which we lose our real personalities.

The most striking feature of this book is perhaps its literary style. Because of his graphic manner of expression, Dr. Maloney is able to clarify concepts which other authors only becloud. Not that **The Magic Cloak** is not replete with new ideas, quite the contrary! The new ideas stun one, both because of their content and because of the impact with which Maloney's language thrusts them upon the reader's consciousness. For psychiatric tomes read like a novel but **The Magic Cloak** has a fascination which is evoked only by really great literature. It is a book which one can enjoy and from which one can profit at the same time.

A word should be said about the illustrations by Erle Loran. Here is a man who can draw a picture of a dream and make it **look** like a dream! Loran's artistic expression packs the same graphic punch as Maloney's literary expression.

We all wear a magic cloak. This Maloney proves in many ways through illuminating case studies of persons of both sexes in all walks of life — policemen, Salvation Army lassies, business magnates, soldiers and housewives. He illustrates again and again the common errors made by parents, which cause each one of us to become a person living within another person. This concept, too, Maloney expresses with graphic clarity. Two people, he says, cannot reside within one body, using the same tissues, the same skeleton, the same nervous system. There is bound to be trouble. Again and again he says, "Two people cannot live within one body." But he explains the use of the magic cloak as well. The cloak is a mantle of omnipotence. A person identifies with the seemingly all-powerful parent. This identification he rationalizes as an identification with God, with majesty, with the armed services, with prison wardens,

with any and all symbols of the original authority of the parent. It is better, says Maloney, to be the one who beats than he who is beaten. It is better to reject than to be rejected. And so we imagine as we go about that we ourselves are omnipotent. All of this is merely a cloak to hide the underlying terror and helplessness felt by most individuals within our neurotic society.

The book is of particular interest to ministers, as it portrays the development of neurotic religious ideas, with which so many of us have to deal. I once had an opportunity to talk to Dr. Maloney about his book, at which time I suggested that he gave religion a rather bad time. He responded immediately "Not healthy religion!" As we peruse the pages of **The Magic Cloak** and are struck again and again with the neurotic elements in our own religious milieu, we tend to wonder just what Maloney does mean by a healthy religion. In the last chapter, "Today's Tomorrow," we find the answer in which the author pictures a generation of people yet unborn, reared to be confident, happy, independent, aggressive and loving. Such persons, he says, are produced when the mother becomes a strong and powerful ally against the forces that beat in on the helpless infant from a hostile world. Too often the mother and the father become a part of the threatening terror with which the rest of the world is invested; but for generations yet unborn he holds out the hope of mastery of the nameless terrors that have plagued the rest of us, lo these many years. In addition to his interest in religion, Maloney shows a wide diversity of interests: in anthropology, in analysis, and sociology; for each of these and many other professions, he explains the underlying unconscious and often neurotic reasons which may drive a person into his or her profession. In his chapter, "The Analyst Wears a Magic Cloak," he paints a picture of an analyst high up on a throne who says in effect "I am the Lord Thy God." Original sin, he says, is "The sin" of the individual's drive toward emancipation and independence. Such a "sin" is often blocked again when one finds himself in analysis, says Maloney, by an analyst who has not himself been allowed complete freedom of expression. After an explanation of the "vision" of St. Paul on the Damascus Road, Maloney adds "Too many analysands behave like Saul. At some point during their relentless authoritarian analysis, they surrender their initiative — they become a carbon copy of the analyst."

Many religious figures are illumined by Maloney's insights — Moses, Saul, even Jesus Christ. Many of the experiences of the children of Israel — the story of Adam and Eve in the garden —

the conversion of Saul — all of these stories come to us in a clearer light. We may not appreciate or fully agree with everything that Maloney says but we are certainly forced to re-think some of our own preconceived theological notions, if we can honestly read **The Magic Cloak.**

In his chapter, "Some Aspects of Success and Failure," those persons who work in penal institutions will find some interesting studies in the lives of criminals. Maloney believes that the criminal is essentially a masochistic individual, not at all the brave he-man pictured by the readlines of the daily newspapers. Most crimes are merely mechanisms by which the "criminal" assures himself of the protection of the "Big House."

There are a number of chapters on the experiences of Dr. Maloney during the war years, studies in leprosy and the psychology thereof, in all kinds of psychosomatic illnesses, in war neuroses. psychoses, a study of the Okinawan natives which Maloney believes to be perhaps the most mentally and emotionally healthy race on earth, and a comparison of oriental and occidental attitudes toward the war. In his chapter, "Beyond the Sexual Principle," Maloney tangles with the great master, Freud. He claims that much greater than the famous castration fear, and at the same time much earlier and much more primary to each individual, is separation anxiety — the fear of being left, the fear of being lost, the fear of what he calls "horrendous reality." He concludes, "In looking beyond the sexual principle, there seems to be only one type of fundamental anxiety, and that is separation anxiety. If the child becomes prematurely separated from the mother, the child dies — or perhaps it would be better to say that anxiety develops because of helplessness, and the individual finds himself incapable of overcoming the separation."

The Magic Cloak is a profound and moving work, the result of many years' study and experience in working with all types of people in all walks of life. It is a valuble book for anyone's library. I am sure that many who read it will violently disagree with some of Maloney's ideas. That is not important. The important thing is that one be familiar with it; for in this work we become acquainted with one of the great men and the great analysts of our time, and one of the great prophets of the future of mankind.

LOUISE LONG

PSYCHOTHERAPY AND A CHRISTIAN VIEW OF MAN by David E. Roberts; 161 pp., Charles Scribner's Sons, New York, 1950; $3.00.

Professor Roberts has presented us with an interesting study in a field that is almost neglected, and that is of increasing importance. He turns attention to the human values to be found in psychotherapy and in theology, for he is concerned for cooperation between these disciplines which so often are remote from one another. They are remote chiefly because of the necessity of specialization with its attendant problems of ignorance of everything else (or worse, partial knowledge), of specialized technical language, of unexamined presuppositions. This study does not set out to state a psychiatric view of religion, which of necessity would have to omit what is central in religion, nor yet a theological evaluation of psychotherapy, which would also be interesting but would at this time be premature. Instead here is an attempt to relate each to the other for the sake of human values found in each of them, and to do so in language understandable by both.

The problem of language is perhaps the greatest problem in this reapprochement. Both of these disciplines have large and often confused technical vocabularies, and neither vocabulary can do justice to the subject matter of the other discipline. Here this problem is avoided by not using technical terms except where they are explained. The laudable and largely successful attempt is made to keep the whole discussion in words that are intelligible to laymen in either field. One defect of this virtue is that much of the discussion sounds more elementary than it is. To discuss either "psychotherapy" or "theology" is to make a sort of abstraction from the contexts of those particular psychotherapies and theologies that exist in fact, and in this short volume there is no room for detailed reference to particular schools in either discipline. This is sometimes annoying, sometimes confusing, sometimes startling and always leaves one wishing for more. To beginners it seems that the writer is arranging straw-men, although this is not so. To enquirers it may lead to the constant questions, "Whose psychotherapy? Whose Theology?" Another defect of this virtue is the constant use of long phrases to explain in the place of terse words to indicate what is known. This unavoidable difficulty seems to be made more pronounced by the writer's liking for long phrases. But virtue it remains.

This intelligible language is made possible by the inductive method in presentations. We are started off with descriptions of

what therapy is good for and how it operates in dealing with anxiety, hostility, self-deceptions and other attitudes which Christians and others regard as problems. The discoveries made by psychotherapy in this work is then examined in relation to reason and faith. Then there is examination of Christian doctrines, (creation, moral freedom, sin and original sin, and salvation) to show at once how useful psychiatric descriptions are of the human side of the experiences formulated in these doctrines and how necessary a Christian world-view is for a full understanding of the personal life revealed in psychotherapy.

It must not be supposed that the aim of the essay is apologetic, proving the validity of each discipline by the other, although their correlations are made clear. The essay is a study of the nature of men, and thus is related to systematic theology and to ethics as well as to apologetics. It is a volume that will be of value both to the preacher and to the counselor as well as to the theologian and, not least, it should be very useful to the psychologist, the psychiatrist and the psychoanalyst.

THOMAS J. BIGHAM, JR.

THE LESSON OF OKINAWA by Newton Dillaway, 34 pp., The Montrose Press, Wakefield, Mass., 1947, $1.00.

This reviewer shares the author's enthusiasm for Dr. James Moloney's account of family life on Okinawa, and particularly for his analysis of the elements which make for a very low incidence of mental illness, and contribute to an unusually wholesome child life. Mr. Dillaway's 'essay' was written after he had seen Dr. Moloney's pictures which illustrated the use of permissiveness in the Okinawan's care of the children. This includes breast feeding until two years of age, toilet training after the child is able to understand and can cooperate, an attitude of appreciation of, and respect for, the child's individuality, which apparently does not produce 'spoiled' children, but an unusually stable, sturdy, and altruistic person.

The thesis is that "Children who are permitted the satisfaction of normal cravings and desires during childhood are thereby released, and they pass into the normal development of later years in which the mother plays a less significant role, in which the child is not unduly aggressive nor afraid, because he has been well handled

during those vital early days." Stating it in theological language the author believes the good results with the children on Okinawa grew out of the intuitive appreciation by the mother that God's way and God's wisdom are inherent in the child, and when these are understood and cultivated, instead of producing sickness as our man-made systems of child management do, they produce vital health as one would expect.

If the author's thesis is correct, it raises the question: How can the church apply the insight in helping to meet the needs of its mothers and their children under four years of age?

ROBERT D. MORRIS

THE COMMON VENTURES OF LIFE by Elton Trueblood, 124 pp., Harpers, N. Y. C.; 1949, $1.00.

This small book of slightly over one hundred pages is written for the layman, and is actually in laymen's language. The author deals with the four most common ventures of life, namely, marriage, birth, work, and death. The purpose of the book is to lift up these most "democratic of experiences" and show that their real meaning is so significant as to be considered sacramental.

The author's obvious intent is writing the book is to create in the reader's mind an attitude and a perspective regarding these common ventures, and this he does accomplish to a remarkable degree. Reverence, humility, and hope — if not challenge — are experienced as one reads. The author does not intend to be clinical and therefore there are no cases cited. Only the most general types of illustrations are used.

There are numerous occasions when a pastor deals with men and women in his parish whose problems are not grossly pathological, and where no long term counselling is indicated, but where a little more perspective and appreciation are needed in regard to the everyday life. For such cases this little book will be very valuable. Ministers might find here some fresh sermon material. It should be stated clearly, however, that this book could do more harm than good when used as a substitute for deeper understanding and insight regarding involved problems.

DON C. SHAW

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